

**ILLINOIS DEPARTMENT OF PUBLIC AID
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

- Federal law says that the Agency cannot share your health information without your permission except in certain situations. If you sign this form, you are giving the Agency permission to share the health information the Agency has with the person you indicate below.
- This Authorization will last until the date you specify or until you tell the Agency you do not want it to share your health information any longer with the person indicated below.
- **Right to Revoke:** If you decide you do not want the Agency to share your health information any longer, sign the Revocation at the end of this form and give this form to the Agency. If the Agency has shared your health information for a research study, the Agency may continue to use or share your health information for that purpose only.
- The Agency (1) cannot refuse payment or deny enrollment or eligibility for benefits if you do not sign this Authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations; and (2) cannot deny treatment if you do not sign this Authorization, unless the treatment and the disclosure are for research purposes; and (3) cannot deny provision of health care if you do not sign this Authorization, unless the provision of the health care is for the purpose of creating health information to share with a third party.
- The Agency cannot promise that the person you permit the Agency to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this Authorization, and can contact the Illinois Department of Public Aid Privacy Officer to get a copy if you do not have one.

My name: Date of birth:

I give permission to: **the Illinois Department of Public Aid** (Agency) (I also give permission to:)

to share my health information checked below with:, or with
Elected Official: (name)

- ☐ All of my health information that the Agency has.
- ☐ All of my health information that the Agency has covering a certain period of time:
from: to:
- ☐ All of my health information that the Agency has relating to a certain event or injury:
event or injury:
date of event or injury:
- ☐ My health information regarding acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
- ☐ My health information regarding behavioral health services or psychiatric care
- ☐ My health information regarding treatment for alcohol and/or substance abuse
- ☐ Other:

Purpose: The Agency may share my health information that it has for this purpose:

- ☐ To assist me with my health care.
- ☐ For a research study.
- ☐ For marketing purposes.
- ☐ Other:

Term of Authorization: The Agency may share my health information from the date of this Authorization **either** until I revoke the Authorization by signing the Revocation of Authorization, below, and giving this form to the Agency, **or** until this date:

Signature: Date:

Signature of Personal Representative: Date:

Relationship of Personal Representative:

REVOCATION OF AUTHORIZATION:

I no longer want the Agency to share my health information with the person indicated above.

Signature: Date:

Send this Authorization Form or Revocation of Authorization to:

Privacy Officer
Illinois Department of Public Aid
P.O. Box 19159
Springfield, IL 62794-9159

Fax: 1-312-793-2005

Contact the Illinois Department of Public Aid Privacy Officer:

P.O. Box 19159
Springfield, IL 62794-9159

Toll-free telephone: 1-800-226-0768 (Health Benefits Hotline)

Toll-free for persons using a TTY: 1-877-204-1012

Fax: 1-312-793-2005

e-mail address: privacyofficer@mail.idpa.state.il.us